



**The Hathaway School**  
50 Blaney Street  
Swampscott, MA 01907  
Phone: 781-595-5859 Fax: 781-595-7064

**FIRST AID EMERGENCY MEDICAL CARE CONSENT FORM: 2010 – 2011**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Student Address: \_\_\_\_\_  
Street Apt. # or Floor  
\_\_\_\_\_  
City State Zip Code

**Instructions to reach parent/guardian:**

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apt. # or Floor City & Zip Code  
Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apt. # or Floor City & Zip Code  
Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

I authorize staff in the childcare program trained in the basics of first aid to give my child first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to \_\_\_\_\_, and to secure necessary medical treatment for my child.

**Child's Physician Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Child Allergies:** \_\_\_\_\_  
**Chronic Health Condition(s):** \_\_\_\_\_

**I, authorize the school to post information about my child's medical condition in the building if necessary.**

**Parent Signature:** \_\_\_\_\_

**Emergency Contacts (OTHER THAN PARENT)**

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Do you give permission for child to be released to this person?**  Yes  No  
1. Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Do you give permission for child to be released to this person?**  Yes  No

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_